

COUNTY OF SAN DIEGO
Health and Human Services Agency
CHILDREN'S MENTAL HEALTH SERVICES
MONTHLY STATUS REPORT

Contractor: _____

Report Month: _____

Contract Number: _____

Date Submitted: _____

Program Name: _____

Instructions: All reports must be received by the 15th calendar day of the month. Send reports to the e-mail addresses listed on Attachment I-A. Thank you for your cooperation.

- 1. NOTEWORTHY ACTIVITIES/UNUSUAL EVENTS** - Extraordinary accomplishments, awards and positive events. Unexpected occurrences or risk management incidents. If none, please write "None."

text box

- 2. COMMUNITY CONTACTS/INTERACTION WITH OTHER AGENCIES** - Special outreach efforts and non-routine contacts or collaboration. If none, please write "None."

text box

- 3. CLIENT COMPLAINTS/GRIEVANCES** - Resolutions or provider response and actions initiated that would lead to a resolution; include school complaints on behalf of children. **Attach "Complaint and Grievance Log"**. If none, please write "None" below.

text box

- 4. PROGRAMMATIC ISSUES AND ACTIONS INITIATED TO SOLVE OR MITIGATE THEM** - If none, please write "None."

text box

- 5. EMERGING ISSUES OR POTENTIAL PROBLEMS** - Current concerns that warrant direction discussion with Program Monitor or anticipatory problem solving. If none, please write "None."

text box

6. **CULTURAL COMPETENCY** - California Department of Mental Health requires the County of San Diego to provide information on cultural competency of service providers of specialty mental health services. To meet this requirement, contractors are required to complete "**Cultural Competency Report**" twice in a fiscal year: (1) initial report month and (2) report month of December. Refer to your contract budget documents: Schedule I for budgeted positions and Schedule II for Consultants.

Attach completed Cultural Competency Form at (1) initial report month and (2) report month of December.

7. **STAFF CHANGES** - Employees who were hired or terminated during the report month. List position, name and credential, date of hire/termination, and ethnicity/languages spoken. If none, please write "None."

text box

8. **STAFF DEVELOPMENT/TRAINING** - Employees who attended a training session, seminar, or workshop. List staff name, course title and the number of hours. If none, please write "None."

text box

9. PROVIDER TRANSFER REQUESTS - Please list below all provider transfer requests made by clients during the report month. If there were none, please write "None."

Reason for Request* (refer to codes below)	Date of Request	Resolution (If not resolved, document follow-up)	Resolution Included Transfer to Another Program		Date Resolved or Referred On
			YES	NO	

Provider Transfer Request was based on the following client preference(s). Please list all relevant codes.

1. Availability: Provider not available during hours client can make appointments or client cannot wait until next available appointment.
2. Geography: Client identifies distance, transportation or other geographical reason for requesting change of provider
3. Language: Client requests provider proficient in a language other than English
4. Ethnicity: Client requests provider of a specified ethnicity
5. Culture: Client requests provider of a specified cultural background (other than ethnicity)
6. Gender/Sexual orientation: Client requests provider of a specified gender or sexual orientation
7. Religious/spiritual orientation: Client requests provider of a specified religious/spiritual orientation
8. Accessibility: Office is not handicapped accessible or does not otherwise meet client's perceived accessibility needs
9. Preference: Client does not like provider
10. Ethics/Complaint: Client expresses ethical concerns regarding provider or had filed a complaint regarding provider
11. Client unwilling or unable to express why provider transfer if being requested

10. STATUS OF MONTHLY REPORTING REQUIREMENTS - Narrative and statistical description of accomplishment of outcome objectives. Include a statement of specific outcome objective and attach a summary of the year-to-date information as appropriate. Refer to particular service modality as delineated in the current Outcome Standards.

Outpatient Service Contractors

Monthly Wait List (document in number of calendar days)		
Total Number on Waiting List	Waiting Time for Initial Visit	Waiting Time for Initial M.D. Evaluation

Case Management Contractors

Average Waiting Time from referral to assignment of case manager (document in number of calendar days)		
Wait Time	Number of Referrals	Average Wait Time

11. ADDITIONAL INFORMATION**A. Service Units and Billing Units**

Refer to your contract document (Contract Budget Summary) to obtain annual budgeted units.

Refer to InSyst report MHS 831 to obtain your actual units for the report month and year-to-date (YTD).

Percent (%) elapsed - YTD actual units divided by annual budgeted units multiplied by 100.

Service Function	Service Units				Billing Units			
	Annual Budgeted	Report Month Actual	YTD Actual	% Elapsed	Annual Budgeted	Report Month Actual	YTD Actual	% Elapsed
MHS								
Med Support								
Crisis Intervention								
C M Brokerage								
Day Tx Intensive								
MHS-R								
Day Rehab								
MHS-TBS								
Other (specify)								

B. Statistical Information

Refer to InSyst MHS 206 for number of admissions ("Open"), discharges ("Closed"), active cases ("End Load") and "Unique Client Count."

Report Item	Report Month	Year to Date
Number of Admissions (Total number as of last calendar day of report month)		
Number of Discharges (Total number as of last calendar day of report month)		
Number of active cases (Total number as last day of report month)	NA	
Number of Incident Reports (Summary of all incident reported as of last day of report month)		
Average Caseload per FTE (Number of active cases divided by the number of FTE clinicians)		NA

Name and Title of Person Completing this Form

For County Use Only

Date Received:

Comments: